Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

HOME AND COMMUNITY BASED WAIVER SERVICES
SELECTION OF PROVIDER FORM

❑ Section I: HCB Waiver Member Demographics (Please print clearly)

Name (Last, First, Middle): _____

Date of Birth: (__ __ / __ __/ __ __ __ __) County of Residence: _____

Medicaid Identification Number (MAID): __ __ __ __ __ __ __ __ __ __ __ (10 digits)

Street: _____

City: _____ State: _____ Zip Code: _____

Member's Telephone #: (_____) _____ Alternate Telephone #: (_____) _____

Representative's Name & Telephone #: _____(_____) _____

❑ Section II: Selection of Provider for Reassessment Service (Please print clearly)

Current Reassessment Provider's Name & Telephone #: _____(_____) _____

Agency's Name: _____ Provider #: _____

I understand that I have the freedom to choose who will provide my HCB Waiver reassessment service. Effective ____/____/_____, I select _____ to provide my reassessment service. I further understand that I am required to update this provider selection form at any time I decide to select a new reassessment provider. I also understand that I have a right to receive a copy of this form and have it explained to me.

Selected Agency's Name: _____Provider #: _____

Agency's address: _____ Telephone #: (_____) _____

❑ Section III: Selection of Provider for Case Management Services (Please print clearly)

Current Case Manager's Name & Telephone #: _____(_____) _____

Agency's Name: _____ Provider #: _____

I understand that I have the freedom to choose who will provide my HCB Waiver case management services. Effective ____/____/_____, I select _____ to provide my case management services. I further understand that I am required to update this provider selection at any time I decide to select a new case management provider. I also understand that I have a right to receive a copy of this form and have it explained to me.

Selected Agency's Name: _____Provider #: _____

Agency's address: _____ Telephone #: (_____) _____

❑ Section IV: Authorized Signatures

- I have read the above information or had the information read to me and my questions were answered to my satisfaction.

Member's or Representative's Signature: _____ Date: _____

- As the **Current** Case Manager, I have fully explained the above information and have provided a copy of this form to the Member and/or the Member's Representative.

Case Manager's Signature: _____ Date: _____

Note: The current Case Manager must submit a copy of the MAP-23 to the PRO and to the selected provider(s) indicated above with every requested change and anytime the MAP 109-HCBW is completed/modified.